CINUP
Employee Benefits for First Nations

EMPLOYEE DISABILITY CHECKLIST

Please complete the enclosed forms in full, and in ink. Ensure all forms are signed and dated where applicable.

- *Direction and Authorization Form*
- *Employee Statement*
- *Attending Physician's Statement (take full package to your attending physician who will complete the appropriate form)*
- *Void cheque*

Mail, fax or email completed forms to:

Mail: **JG Benefits Inc.**
1051 King Edward Street
Winnipeg, MB R3H 0R4

Fax: **1-833-702-4687**

Email: **disability@cinup.ca**

Should you have any questions, please contact the CINUP Disability team at 1-800-665-1234

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Megan Wood
Employee's (Claimant Name)

TO Desjardins Financial

RE RELEASE OF CONFIDENTIAL/PERSONAL INFORMATION TO JG Benefits Inc./CINUP (hereinafter "Policyholder")

INDIVIDUAL POLICY NUMBER : Select Policy Number

I hereby direct and authorize the company to discuss with the Policyholder (JG Benefits Inc./CINUP) any and all information or documentation concerning my claim and its evaluation by the company, including but not limited to, any medical, financial, vocational, rehabilitation, or any other confidential/personal information or documentation concerning my claim. I also authorize the Company (Desjardins Financial) to send to the policyholder, copies of correspondence the Company receives from me concerning my claim as well as any medical information received from external sources.

Duration and Revocation

I understand that

- It is not a requirement of the Policy/Policies that I authorize the company to disclose information to the Policyholder
- This authorization will remain valid for as long as I am claiming benefits or service from the Company: and,
- I am free to revoke this authorization at any time by sending written notice to the Company of such revocation.

I have read and understand the above. I am signing this voluntarily, and not under compulsion by anyone.

Signature of Claimant

Date

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Contact us: 1-800-263-1810 (toll free) or 416-926-2990

Desjardins Insurance
Life · Health · Retirement

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM
EMPLOYEE STATEMENT

The payment of your disability claim will be made by direct deposit only. Please include a specimen cheque marked «VOID».

A - IDENTIFICATION

We are unable to assess this claim unless all questions are answered completely.

Last name and first name of employee: Wood Megan

Sex: ☐ M ☒ F

Date of birth (YYYY MM DD): 1995 07 07

Address - No., street, apt.: 235 Brock St. E

City: Thunder Bay

Province: ON

Postal code: P7E 4H3

Policy or group or contract no.	Division no.	Certificate or identification no.	Social insurance no.[1]
641028	59086	0063471949	540 278 918

Telephone no. (mandatory): (807) 626-3719

☒ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address[2]: mwood@nanlegal.on.ca

[1] Your social insurance number is necessary only if your disability claims are taxable. Please contact your employer to obtain this information.
[2] Please provide this information only if you authorize Desjardins Insurance to email you.

B - GENERAL INFORMATION

1 Training: Staff Lawyer.
Level of education: 7 + years of university.
Work experience: 2 + years

Spoken language: ☒ English ☐ French Written language: ☒ English ☐ French

2 Is disability due to an accident? ☐ Yes ☒ No
If "Yes", date of accident: YYYY MM DD
Time: ☐ AM ☐ PM
Type of accident: ☐ Work-related ☐ Motor vehicle ☐ Other

Indicate details (where, how):

3 Did you receive prior treatment for the illness or injury causing the disability? ☐ Yes ☒ No
If "Yes", give particulars including name, address and telephone number of all treating physicians and specialists:

4 Name, address and telephone number of physicians and specialists who have treated you during the disability:

Kelsey York, NP – Lakehead Nurse Practitioners Clinic, Unit 101 325 Archibald Street S. Thunder Bay, ON.
807-475-9595

PLEASE COMPLETE THE BACK OF THE FORM.

B - GENERAL INFORMATION (CONTINUED)

5 If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy no.	Certificate no.	Start date of benefits (YYYY MM DD)	End date of benefits (YYYY MM DD)	Benefit amount	Weekly/Monthly
N/A.					$	☐ W ☐ M
					$	☐ W ☐ M

Comments:

C - DIRECT DEPOSIT ENROLMENT

Please include a specimen cheque marked "VOID".

I hereby authorize Desjardins Insurance to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution	Institution no.	Transit/branch no.	Account no.
RBC	003	05782	5060520

Address - No., street, suite	City	Province	Postal code
2600 Arthur St. E	Thunder Bay	ON	P7E 5R4.

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on Oct. 3/22. The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: [signature] **Date:** October 3, 2022.

D - PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.

E - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim.

I hereby certify that the above answers are full and true. I authorize Desjardins Insurance strictly for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or facilities, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

Provided that I have filled out the appropriate boxes, I authorize Desjardins Insurance to email me at the address provided in section A of this form and I give Desjardins Insurance permission to leave voicemail about my disability claim at the phone number provided on this form.

I authorize Desjardins Insurance to use or communicate my social insurance number for tax purposes. A photocopy of this authorization is as valid as the original.

Signature of employee: [signature] **Date:** October 3, 2022.

VERY IMPORTANT

Please have the Initial attending physician's statement completed and submit the completed forms online, or by mail or fax to: Desjardins Insurance – Disability Claims.

October 3, 2022

To: Whom it may concern

Re: Void Cheque

Please accept this copy of a void cheque as confirmation of MEGAN WOOD's bank account information for the purposes of pre-authorized debit or credit.

MEGAN WOOD

934 MOUNTDALE AVENUE
THUNDER BAY, ON
P7E2Z9

Date: 2022 10 03
YYYY MM DD

$

VOID

Transit Number:	Institution Number:	Account Number:
07782	003	5060520

07782

Attending Physician Statement

(Please take full package to your physician)

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins
Insurance
Life · Health · Retirement

INITIAL ATTENDING PHYSICIAN'S STATEMENT GENERAL FORM

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)	Policy or group or contract no.	Certificate or identification no.	Date of birth
	641028		YYYY MM DD

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications) - If psychiatric, give DSM-IV code.

1.1 Primary: _____

1.2 Secondary: _____

1.3 Subjective symptoms (including severity, frequency, duration): _____

1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings): _____

1.5 Degree of severity of all symptoms: ☐ Mild ☐ Moderate ☐ Severe ☐ With psychotic elements

2. History

2.1 Date symptoms first appeared or accident happened: YYYY MM DD

2.2 Date patient's condition first prevented them from working: YYYY MM DD

2.3 Has this patient ever had same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, please specify diagnosis and dates of treatment: _____

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☐ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☐ No ☐ Unknown

2.6 If patient is pregnant, give E.D.C.: YYYY MM DD

2.7 Names and specialties of other treating physicians: _____

2.8 Current height: Current weight: Weight loss/gain to date:

3. Treatment dates

3.1 Date of first visit for current condition: YYYY MM DD

3.2 Date of latest visit: YYYY MM DD

3.3 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

3.4 Date of in-patient admission: YYYY MM DD

3.5 Date of discharge: YYYY MM DD

3.6 Date of out-patient treatment: YYYY MM DD

3.7 Name of hospital: _____

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Surgeries (including dates): _____

4.3 Other (including frequency): _____

4.4 Is patient following recommended treatment program? ☐ Yes ☐ No (please elaborate): _____

Submit online:
desjardinslifeinsurance.com/send
Complete and save the form on your computer first.
Keep original forms for your records.

By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins Insurance
Life · Health · Retirement

INITIAL ATTENDING PHYSICIAN'S STATEMENT MUSCULO-SKELETAL FORM

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)	Policy or group or contract no.	Certificate or identification no.	Date of birth
	641028		YYYY MM DD

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis

1.1 Primary: _____

_____

1.2 Secondary: _____

_____

1.3 Date symptoms first appeared: _____ YYYY MM DD

1.4 Date patient's condition first prevented them from working: _____ YYYY MM DD

1.5 Date of first visit for treatment or consultation: _____ YYYY MM DD

1.6 Has patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown If yes, state when and describe:

_____

1.7 Is condition a result of an injury due to an accident? ☐ Yes ☐ No If yes, please describe:

_____

1.8 Current height: _____ Current weight: _____ Weight loss/gain to date: _____

1.9 Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
If yes, have Worker's Compensation/CNESST forms been completed? ☐ Yes ☐ No

1.10 Date of latest visit: _____ YYYY MM DD

1.11 Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify): _____

1.12 Date of hospital inpatient admission: _____ YYYY MM DD

1.13 Date of discharge: _____ YYYY MM DD

1.14 Date of hospital outpatient admission: _____ YYYY MM DD

1.15 Name of hospital: _____

1.16 Other treating physicians: _____

1.17 Pending referrals to specialists: _____

2. Studies

Please outline all objective studies performed/scheduled (X-rays, laboratory data, CT scans, etc.) and attach copies of each report.

Date	Procedure	Results
YYYY MM DD		
YYYY MM DD		
YYYY MM DD		
YYYY MM DD		

8. Assessment and treatment are complicated by: (please select and explain in the space provided below)

8.1 ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.

8.2 ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.

8.3 ☐ Work related issues (please describe if known): _____

8.4 ☐ Substance abuse: _____

8.5 ☐ Other (please describe): _____

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? ☐ Yes ☐ No

9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No

If yes to either of the above, please specify: _____

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

_____

_____

_____

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT) | 11.2 Specialty | License no.

11.3 Address - No., street, suite | City | Province | Postal code

11.4 Telephone no.: ( ) - Fax no.: ( ) -

Signature of physician: **Date:**

5. Current treatment

5.1 Therapy method: _____

5.2 Therapy goal: _____

5.3 Frequency and length of therapy/counselling sessions: _____

5.4 Number of therapy/counselling sessions to date: _____

5.5 Treatment compliance: _____

5.6 Treatment response to date: _____

5.7 Prognosis and time frame of illness: _____

Medications: Medication name				
Date started	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD
Initial dosage				
Initial response				
Date of last dosage change	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD
Current dosage				
Response				
Side effects				
Compliance				
Date medication discontinued	YYYY MM DD	YYYY MM DD	YYYY MM DD	YYYY MM DD

6. Future treatment plans

What changes in your treatment plan are underway or are being considered?

_____

_____

7. Return to work plans

7.1 Prognosis for recovery: _____

7.2 Expected date patient will return to their own occupation: _____ YYYY MM DD

7.3 If unknown, please indicate the next follow up date: _____ YYYY MM DD

7.4 If your patient is unable to return to their regular occupation, please specifywhen and under what circumstances they could return to work (eg. modified duties, gradual return to work.): _____

_____

7.5 Have return to work time lines been discussed with the patient? ☐ Yes ☐ No

7.6 Please elaborate on time frames and patient's response: _____

_____

7.7 Is your patient a suitable candidate for vocational rehabilitation? ☐ Yes ☐ No If yes, please specify: _____

_____

7.8 When and under what circumstances could patient return to modified duties or a gradual return to work? _____

8. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition, treatment requirements, and motivation to return to work? _____

_____

_____

9. Identification of physician

9.1 Last name and first name (PLEASE PRINT) | 9.2 Specialty | License no.

_____ | _____ | _____

9.3 Address - No., street, suite | City | Province | Postal code

_____ | _____ | _____ | _____

9.4 Telephone no.: ( ) - | Fax no.: ( ) -

_____ | _____

Signature of physician: | Date:

_____ | _____

5. Restrictions and limitations

5.1 Functional capacity: (Canadian Cardio-Vascular Society (CCS))

☐ Level 1 (no limitation) ☐ Level 2 (mild impairment) ☐ Level 3 (moderate impairment) ☐ Level 4 (severe impairment)

5.2 Functional capacity:

Lifting/Carrying	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Pushing/Pulling	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Standing: _____ hours Walking: _____ blocks Driver's license revoked: ☐ Yes ☐ No		Frequency: _____ Duration: _____

5.3 What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation? _____

5.4 How does this affect the patient's ability to perform activities of daily living? _____

6. Return to work plans

6.1 Prognosis for medical recovery: _____

6.2 Expected date patient will return to their own occupation: _____

6.3 If unknown, please indicate the next follow up date: _____

6.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work:

7. Assessment and treatment are complicated by: please select and explain in the space provided below.

7.1 ☐ Significant emotional or behavioural disorder such as depression, anxiety, etc.

7.2 ☐ Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations

7.3 ☐ Work-related issues (please describe if known): _____

7.4 ☐ Substance abuse

7.5 ☐ Other (please describe):

8. Progress

8.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

8.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): ☐ Yes ☐ No

If yes, please specify: _____

9.2 Is patient a suitable candidate for vocation rehabilitation? ☐ Yes ☐ No If yes, please specify: _____

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

_____

_____

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT) | 11.2 Specialty | License no.

11.3 Address - No., street, suite | City | Province | Postal code

11.4 Telephone no.: ( ) - Fax no.: ( ) -

Signature of physician: **Date:**

5. Therapies

5.1 Describe the therapies to date: ☐ N/A ☐ Partial ☐ Complete

5.2 Describe all co-morbid conditions: _____

5.3 Describe any post therapy sequelae: _____

5.4 Please provide the patient's prognosis for improvement and/or recovery: _____

5.5 Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

6. Patient's current physical abilities

6.1 Please indicate your patient's current physical abilities:

☐ Sedentary duties: Mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light duties: Frequent handling of loads of up to 5 kg, sometimes up to 11 kg; may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.

☐ Medium duties: Frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.

☐ Heavy duties: Frequent handling of loads up to 23 kg, sometimes up to 45 kg.

6.2 In your opinion, what is the earliest date your patient will be able to return to work? _____ YYYY MM DD

6.3 If the previous job could be modified, when could rehabilitation employment commence? _____ YYYY MM DD

7. Comments

7.1 Please provide the names of other physicians who have been/will be involved in assessing the medical problems **and copies of any available consultation reports:** _____

7.2 We would appreciate any additional comments that would help us to better understand your patient and their condition:

8. Identification of physician

8.1 Last name and first name (PLEASE PRINT) | **8.2** Specialty | License no.

8.3 Address - No., street, suite | City | Province | Postal code

8.4 Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: | **Date:**

Desjardins
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GROUP INSURANCE - DISABILITY CLAIMS

IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

- General	**Form no. 12018E01**
- Musculo-skeletal	**Form no. 12019E01**
- Psychiatric/psychological	**Form no. 12020E01**
- Cardiac	**Form no. 12021E01**
- Cancer	**Form no. 12022E01**

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Short Term Disability: Return the complete form to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, as soon as possible.

Long Term Disability: Return the complete form to Desjardins Insurance no later than six weeks prior to the start of your long-term disability period.

Online: desjardinslifeinsurance.com/send

Desjardins Insurance
PO Box 1203 STN A
Toronto ON M5W 1G6

Fax: 416-926-0697 or 1-844-409-6571